Performance Audit Report

Department of Health and Mental Hygiene
Mental Hygiene Administration
Community Services Program

Rate Structure and Inadequate Oversight May Have Contributed to an Increase in Certain Program Expenditures

Controls Over Certain Service Authorizations and Claim Payments Were Insufficient

December 2002

Office of Legislative Audits
Department of Legislative Services
Maryland General Assembly

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DEPARTMENT OF LEGISLATIVE SERVICES
OFFICE OF LEGISLATIVE AUDITS
MARYLAND GENERAL ASSEMBLY

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December 23, 2002

Senator Nathaniel J. McFadden, Co-Chair, Joint Audit Committee
Delegate Samuel I. Rosenberg, Co-Chair, Joint Audit Committee
Members of Joint Audit Committee
Annapolis, Maryland

Ladies and Gentlemen:

We conducted a performance audit to evaluate the effectiveness of the Department of Health and Mental Hygiene – Mental Hygiene Administration's rate setting and claims payment procedures. Our audit was limited to the Administration's Community Services Program and was requested by the April 2002 Joint Chairmen's Report of the Maryland General Assembly.

Our audit disclosed significant problems with both the Administration's rate setting and claim payment process that adversely impacted the monitoring of providers, control of mental health expenditures, and the maximization of the program cost recoveries. In general, the Administration's Program oversight needs to be enhanced to ensure that services rendered by providers were necessary and, in certain cases, cost effective. According to the Administration, this situation is complicated by the difficult task of providing broad access to services for consumers, while establishing adequate fiscal controls and safeguards.

We identified a number of problems with the Administration's Psychiatric Rehabilitation Program (PRP), which we believe has contributed to the significant growth in expenditures, which for fiscal year 2002 are projected (after all claims are paid) to be about $110 million, or 25% of total mental health services payments. First, the Administration could not document how the PRP rates were developed, which are paid on a fee-for-service basis. Second, the rate schedule did not provide discounts for group treatments, a common practice for other mental health programs. Third, the governing regulations were very general about the types of eligible services. In addition, treatment authorizations also lacked specificity. These factors affected the Administration's ability to determine whether services rendered by the providers (such as shopping or recreational trips) and paid for by the Administration were reasonable. Finally, statistical data had not been developed to evaluate the PRP's success in meeting the goal of preparing individuals for independent living.

In addition, there was a general lack of oversight to ensure the propriety of all services paid, not just the PRP. For example, even though a post-payment claims review process was in place, inpatient hospital claims, which totaled over $80 million annually, were not covered by the process, nor was there a formal risk-based analysis of payment data to identify possible fraudulent claims or providers for review.

Also, the Administration did not take timely action to minimize costs, or recover overpayments and Federal funds. For example, although the Administration estimated that the expansion of a capitation program for high cost customers could save $9 million annually, action was not taken due to unresolved issues with the Department's process for receiving Federal funds. Also, we identified potential recoveries from various sources of over $8 million and a receivable of $3 million which was abated without sufficient supporting documentation.

An executive summary can be found on page 5 of the report. Our objectives, scope, and methodology of the audit are explained in detail on page 15.

We wish to acknowledge the cooperation extended to us during our audit by the Department of Health and Mental Hygiene.

Respectfully submitted,

Bruce A. Myers, CPA
Legislative Auditor

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Executive Summary

Background

We conducted a performance to assess the adequacy of the Administrations' rate setting and claims payment processes related to its Community Services Program. The Administration's budget primarily consists of funds to pay for specialty mental health services furnished by private providers. Most of these services are provided to Medicaid consumers, which are generally funded 50% by the Federal government and 50% with State General funds. The Administration contracted with an administrative services organization (ASO), which amongst other duties, pre-authorizes services, verifies that claims from providers are for authorized services and pays providers. Services are generally provided on a fee-for-service basis, meaning that providers are paid for each service rendered based on rates, most of which, are established by the Administration.

Provider Payments have increased more than 50% in the last 5 years.

Under the current fee-for-service system, which was implemented in fiscal year 1998, the Administration has the challenging task of ensuring that services paid for were actually provided and were medically necessary. Over the past five years the current system has been in place, annual payments to providers have increased more than 50% from $264 million for fiscal year 1998 to $414 million for fiscal year 2002. This growth over the last two fiscal years, has resulted in the Administration's expenditures greatly exceeding the original appropriations.

Conclusions

Administration appears compelled to pay for services without sufficient regard of fiscal consequences.

Our audit raises significant concerns about the effectiveness of the Administration's rate setting and claims processing procedures, often with a detrimental impact on finances. The Administration's lack of aggressive oversight of certain rate setting processes, coupled with insufficient procedures to ensure that payments are made for medically necessary services contributed to the escalation of the State's mental health care costs. This trend will continue unless more stringent regulations, controls and procedures are instituted and enforced. It is our sense that the Administration feels compelled to meet the wants of the consumers and providers without sufficient consideration of the cost implications.

Objective 1 – Adequacy of Rate Setting Process

Rates For the Largest Category of Services May be Excessive.

Our audit disclosed significant concerns about the rate setting procedures. In certain cases, the Administration did not place adequate emphasis on ensuring that rates paid to providers were reasonable in relation to the services provided. Specifically, reimbursement rates for rehabilitation services, which are the largest category of services with annual costs exceeding $110 million, appeared to be excessive under certain circumstances. Over the past several years rehabilitation services have experienced a rapid growth in utilization, which Administration management believes is at least partly attributable to the more profitable nature of the services. For example, providers were able to bill on a per-person basis for group services provided by a single staff member. The Administration had not established group therapy discounts to control costs or established a maximum consumer to staff ratio to ensure the effective delivery of services.

Opportunities to reduce costs without effecting the adequacy of treatment were not taken.

Other areas of concern include allowing certain fee-for-service providers to retain resources (for example, Federal benefit checks) received on behalf of consumers, without ensuring that these resources were factored into the rates. We also noted that even though the Administration had estimated that an annual cost avoidance of approximately $9 million could be achieved by expanding a capitation program for targeted high cost consumers (replacing fee-for-service); the expansion was not implemented.

Finally, for the Administration's largest single provider (a specialty hospital, not regulated by the Health Services Cost Review Commission), there was no methodology to ensure the adequacy of costs and related rates, which for certain services were much higher than the rates paid to other providers for similar services. Also, cost settlements for this provider have not been completed since fiscal year 1993. These settlements, which compare the actual cost of care to the payments received from the State have not been finalized for fiscal years 1994 to 2001. Provider records indicate that $4 million may be owed to the State for those years, although Department officials believe that the final amount could be even higher.

Objective 2 – Adequacy of Claims Payment Process

Problems were noted with various aspects of the Administration's processes related to claims payments and the necessity and cost effectiveness of certain services. Many of these issues were caused by the Administration failing to adhere to existing regulations. All the claims payment issues have some potential financial impact, although not necessarily measurable, and appropriate corrective action should result in cost savings.

Claims were paid beyond time period established by regulation and the claims review process was not comprehensive.

These findings included the failure to perform reviews of the treatment authorization decisions made by the ASO as required by State regulations, an ineffective claims review process to detect provider fraud and abuse and paying claims beyond the legally mandated submission deadline. Collectively, these findings indicate significant weaknesses in the claims payment process and could ultimately result in inappropriate payments, without detection. However, even when the Administration detected inappropriate payments in the past, its collection efforts were neither timely nor effective. In addition, we estimate that Federal funds in excess of $4.5 million were lost, because of inaction by the Administration, such as not obtaining timely Federal approval for a capitation program.

Eligibility criteria was not always established and treatment success was not evaluated.

We also noted problems with the Administration's rehabilitation services, the most expensive component of the Community Services Program. For example, the Administration had not established eligibility criteria for certain covered services, treatment authorizations for PRP were vague regarding the exact nature of the service to be provided and formal evaluations were not performed to assess the success of PRP treatments.

Finally, we noted that the parent company of the ASO is in a distressed financial condition, yet the Administration has not developed a contingency plan to replace the current payment system, if necessary.

Recommendations

The Administration needs to place greater emphasis on controls to ensure that services are provided effectively and efficiently.

We recommend that the Administration establish or enhance rate setting and claims processing procedures to ensure the efficient and effective use of State resources. For example, State law now requires an annual evaluation of the rates, although the first required evaluation has not yet been completed. It is critical that this annual evaluation include a critical assessment of all rates and services, including rehabilitation services since there is an indication that these rates might be excessive. The Administration also needs to develop an effective process for ensuring that claims are only paid for appropriate and authorized services, in accordance with regulatory requirements. Finally, all opportunities for cost recovery or savings should be actively pursued. More specific recommendations follow each audit finding.

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Background Information

Responsibilities of the Mental Hygiene Administration

The Mental Hygiene Administration is the unit of the Department of Health and Mental Hygiene that is responsible for overseeing the delivery of public mental health services in Maryland. Approximately 99% of the Administration's expenditures, which totaled $488 million during fiscal year 2002, were made in the Community Services Program and consisted primarily of payments to mental health providers and grants to core service agencies. Payments to mental health providers for services rendered during fiscal year 2002 are projected to total approximately $414 million. In fiscal year 2002, the Administration awarded grants to core service agencies totaling approximately $54 million. The fiscal activities of the core service agencies were excluded from this audit. The Administration also oversees the operation of State psychiatric hospitals and residential treatment facilities for adolescents, which are not part of the Community Service Program.

Relationship with Medicaid

Consistent with approval obtained from the Federal government and legislation enacted by the Maryland General Assembly during the 1996 Legislative Session, the Medical Care Programs Administration implemented HealthChoice in June 1997. Under HealthChoice, Medicaid consumers are required to enroll in managed care organizations (MCOs). The MCOs agree to provide comprehensive health care coverage to enrollees for a specified fee per enrollee. However, the MCOs do not provide specialty mental health services. Instead, the Mental Hygiene Administration is responsible for administering mental health services to Medicaid consumers, primarily on a fee-for-service basis.

Claims Payment System

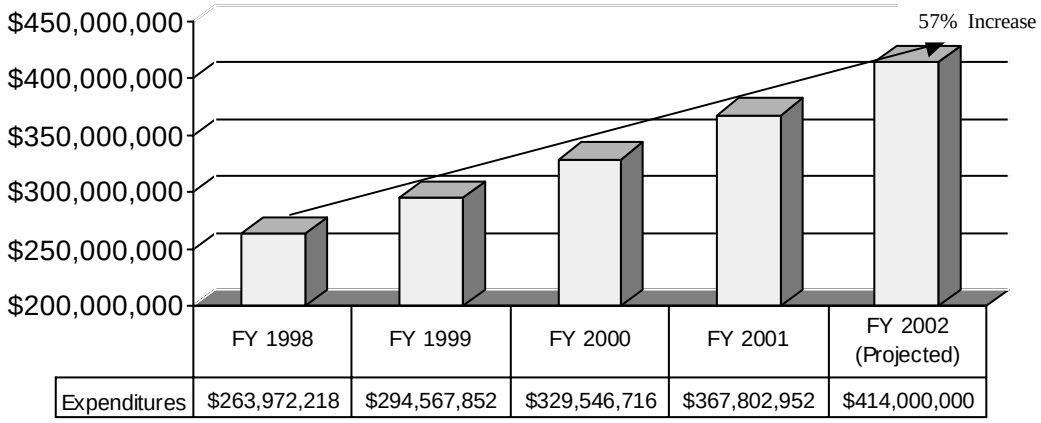
A fee-for-service system is primarily used for service delivery and provider reimbursement, meaning providers are paid for each mental health service that is provided to an eligible consumer. To receive services, consumers or providers must first receive authorization from the administrative service organization (ASO). Before authorizing certain services, the providers must submit a treatment plan to the ASO. After services are authorized and rendered, the providers submit claims to the ASO. The ASO verifies that the services on the claim forms were authorized and processes the claims through a series of edits (such as for duplicate

payments.). The ASO pays the providers for approved claims and is reimbursed by the Administration.

The current fee-for-service health care system has two inherent challenges. First, neither the providers nor the ASO have any incentive to limit the services provided. In fact, since providers' revenues are based on the services provided, there is a financial incentive to provide as many services as possible. The ASO is paid a fixed-fee for administering the system, regardless of the level of activity. Second, with fee-for-service systems, the payer generally has no mechanism for verifying in advance if services billed by providers were actually provided. To detect improper payments to providers, the Administration must rely on service utilization systems and audits of paid claims.

As depicted by the following two graphs, since the implementation of the current system in fiscal year 1998, claims expenditures have increased significantly, exceeding the rate of growth in the number of consumers. This data includes recipients receiving services under Maryland's Uninsured, Medicaid and Medicaid/Medicare Programs.

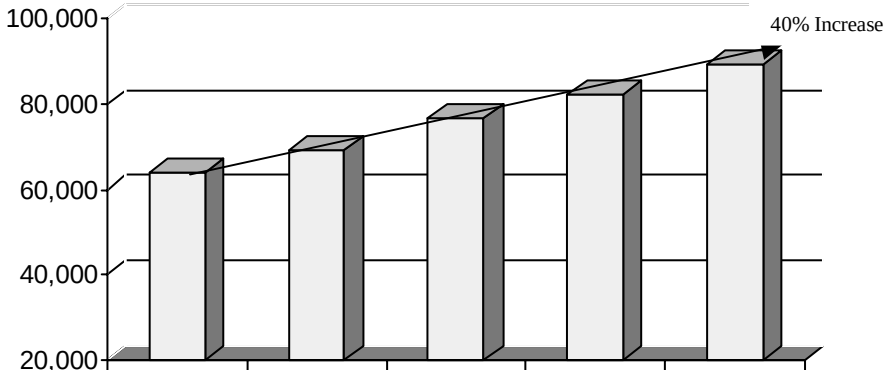
Claims Expenditures for the Mental Hygiene Administration



	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002 (Projected)
Expenditures	$263,972,218	$294,567,852	$329,546,716	$367,802,952	$414,000,000

Source: ASO and Office of Legislative Audits Projection

Consumers Served by the Mental Hygiene Administration



	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002 (Projected)
Customer Count	63,964	69,098	76,751	82,398	89,450

Source: ASO and Office of Legislative Audits Projection

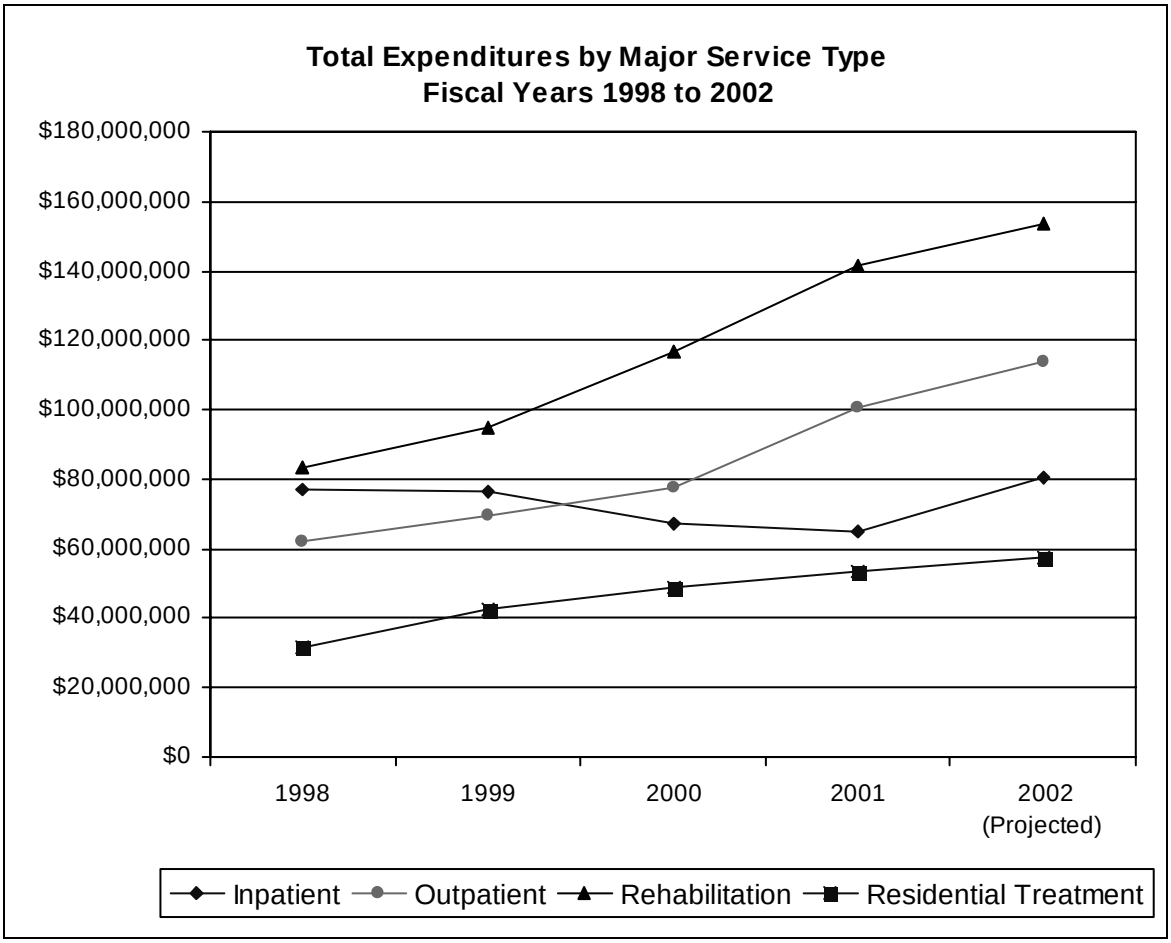
For Medicaid eligible consumers, the ASO is also responsible for submitting the processed claims to the Medical Care Programs Administration, which in turn submits the claims to the Federal government to obtain Federal funding. Generally, the Federal Government pays the State 50% of the cost of services provided to Medicaid consumers. Approximately 84% of services provided under the fee-for-service system are for the Medicaid-eligible population.

In addition to providing services to Medicaid consumers, through fiscal year 2002 the Administration also provided services under the same fee-for-service system to low-income individuals who do not qualify for Medicaid. As stated in the April 2002 report of the Joint Chairmen of the Senate Budget and Taxation and the House Appropriations Committees, effective July 1, 2002, the Administration is required to serve the Medicaid-ineligible population through a series of grants and contracts instead of through the fee-for-service system.

The primary categories of mental health services provided are listed below:

Major Categories of Services Provided & Rate Setting Responsibility	
Inpatient	Inpatient services include expenditures for acute psychiatric treatment of consumers in psychiatric units of acute general hospitals and for the treatment of consumers in private psychiatric hospitals. The Health Services Cost Review Commission establishes rates for these services, except for specialty hospital services.
Outpatient	Outpatient services include mental health services provided by outpatient clinics such as counseling; private practitioners such as psychiatrists, psychologists and social workers; and hospital outpatient services. Rates for these services, except for specialty hospital services, are established by the Administration and are published in the Code of Maryland Regulations.
Rehabilitation Services	Rehabilitation services include providing support in activities of daily living, medication management, and funding for residential rehabilitation services. These services also includes the Psychiatric Rehabilitation Program (PRP), which provides instruction in self-care and independent living skills, and the Residential Rehabilitation Program (RRP), in which an adult consumer obtains the support in a residential setting outside a consumer's own home (i.e., group home). Rates for these services are established by the Administration and are published in the Code of Maryland Regulations.
Residential Treatment Centers	Residential treatment centers provide inpatient psychiatric treatment to children and adolescents. The average length of stay in a center is longer than for other inpatient facilities. Centers have educational components and have a much lower daily cost than the other inpatient facilities. Rates for these services are established by a cost settlement process, subject to maximum rates promulgated in State regulations.

The following chart depicts the relative growth in expenditures in the major categories of services. Much of the growth in the Administration's total expenditures can be attributed to the rapid growth in rehabilitation services.



Source: ASO and Office of Legislative Audits Projection

Additionally, appropriations for mental health services have not kept pace with the aforementioned growth in the expenditures, resulting in significant deficits. As summarized below, the Administration's Community Service Program expenditures have exceeded its original appropriations during the last two years. The Administration was able to legally spend in excess of its original appropriations through a series of budget amendments that transferred funds to the Administration.

Fiscal Year	Legislative Appropriation	Actual Expenditures	Difference
2001	$ 394,739,595	$ 442,095,991	$ (47,356,396)
2002	405,504,376	481,774,843	(76,270,467)
Totals	**$ 800,243,971**	**$ 923,870,834**	**$ (123,626,863)**

In addition to the above-noted expenditures, the Administration has estimated that expenditures of approximately $31 million relating to services provided during fiscal year 2002 will be paid out of subsequent years' appropriations.

Chapter 464 of the Laws of Maryland for 2002 requires the Department of Health and Mental Hygiene to establish an annual process to reassess the rates for the public mental health system. The Department has retained a consultant to address this process and has convened a rate study group to assist the consultant. The Department anticipates a report to be completed by February 2003.

The April 2002 report of the Joint Chairmen of the Senate Budget and Taxation and the House Appropriations Committees requested the Office of Legislative Audits to conduct a performance audit on the Administration's Community Services Program. The results of the audit were to be reported to the Committees by December 1, 2002. Subsequently, the Chairmen of the Committees granted an extension to submit the audit report by January 7, 2003.

Audit Scope, Objectives, and Methodology

Scope

We conducted a performance audit to evaluate the effectiveness of the Mental Hygiene Administration's rate setting and claims payment procedures for the Community Services Program. Our audit was limited to the Administration's Community Services Program as requested by the April 2002 Joint Chairmen's Report of the Maryland General Assembly. Our audit was conducted under the authority of the State Government Article, Section 2-1221 of the Annotated Code of Maryland and was performed in accordance with generally accepted government auditing standards.

Objectives

We had two specific audit objectives:

(1) To determine whether the Administration's rate-setting process for certain types of services results in reasonable reimbursements and to determine if alternatives to the fee-for-service system can be used to reduce costs.

(2) To determine whether the Administration's claims payment process is effective to ensure that services paid for were actually provided, that the level of services rendered was appropriate and necessary and that available cost recoveries were obtained.

Our audit objectives did not include a determination of the effectiveness of the services provided to the Administration's consumers, nor did we review the Administration's grant process related to core service agencies, which received $54 million in grants during fiscal year 2002. The Administration's expenditures totaled $488 million during fiscal year 2002, most of which was for payments to mental health providers.

Methodology

To accomplish our objectives, we reviewed applicable Federal and State laws and regulations as well as policies and procedures established by the Administration and its ASO. We interviewed Administration personnel responsible for establishing polices and drafting regulations, as well as personnel from the Medical Care Programs Administration, the ASO, and providers. We also

obtained an electronic version of claims processed by the ASO for services rendered during fiscal years 2001 and 2002 and performed automated analyses of the data.

We reviewed the medical records of consumers at six large providers to determine if services paid for were documented and in compliance with program criteria. Our audit also included a review of claim reviews performed by a company under contract with the ASO. We also analyzed certain rates that were established by the Administration. We compared certain Administration policies and procedures to practices in several other states. Finally, we reviewed relevant professional literature.

Projection of Fiscal Year 2002 Claims Expenditures

By State regulation, providers can initially submit mental health service claims to the ASO for payment up to nine months after the date of service. For example, claims for services performed during fiscal year 2002 can be submitted for payment until March 31, 2003. For purposes of this audit, we projected fiscal year 2002 claims expenditures. Our projections were based on actual fiscal year 2002 claims submitted as of September 30, 2002, which was provided by the ASO (unaudited), and projected through March 31, 2003 using fiscal year 2001 claims history. While we believe this method to provide a reasonable basis for the projections, actual claims expenditures for fiscal year 2002 may be greater or less than projected.

Fieldwork and Agency Responses

We conducted our fieldwork from May 2002 to November 2002. The Department's response to our findings and recommendations, is included as an appendix to this report. As prescribed in the State Government Article, Section 2-1224 of the Annotated code of Maryland, we will advise the Department regarding the results of our review of its response.

Findings and Recommendations

Adequacy of Rate Setting Process

Conclusion

Our audit disclosed that sufficient attention was not given to the rates paid for certain mental health services. While the potential financial impact could not always be quantified, our findings indicate that improvements could be realized in the Administration's overall cost effectiveness, and program expenditures should be reduced.

Most significantly, we noted that the Administration could not document how provider rates were established for the Psychiatric Rehabilitation Program (PRP), which is the largest single program within Rehabilitation Services, and for which fiscal year 2002 costs are projected to exceed $110 million. While we were therefore unable to assess the reasonableness of these costs, we noted certain practices that do not encourage cost containment. For example, the rates do not allow for group treatment discounts (which is a common practice for other mental health programs). We noted that eight consumers in a one-hour PRP treatment with a non-medical professional employee (such as shopping and recreational trips) would cost the State $424, while the same eight consumers in a one-hour group therapy session with a psychiatrist would cost $184.

Rates for the Residential Rehabilitation Program (RRP), for which fiscal year 2002 costs are projected to be $26 million, were established without consideration of a potentially significant income source for the providers. Specifically, financial support (such Federal benefit checks) for the consumers were retained by the providers to offset the cost of care, but the Administration did not know the number of consumers receiving these checks or the value of the benefits retained.

The Administration could potentially realize an annual cost avoidance of $9 million if it would expand an existing capitation rate program which pays providers a fixed fee per consumer by allowing certain high cost consumers to transfer from the fee-for-service program. Finally, the recovery of $4 million in overpayments from the Administration's largest provider had been delayed for years. The Administration did not routinely analyze this provider's costs to determine if they were reasonable in relation to the services rendered.

Finding 1
The Administration could not document how the rates for certain rehabilitation services were developed. Furthermore, the rates did not provide for group discounts and, in certain cases, did not take into account different periods of service.

Analysis

The Administration was unable to document how it calculated the rates for Psychiatric Rehabilitation Services (PRP), for which fiscal year 2002 claims are projected to exceed $110 million. Although the Administration hired consultants over the past two years to perform 13 studies related to financial difficulties experienced by outpatient mental health clinics and to assess the adequacy of outpatient rates, no studies have been conducted to specifically assess the adequacy of PRP rates, even though rehabilitation service payments, of which PRP is the most significant piece, have significantly exceeded outpatient payments.

According to Administration management, no studies of PRP rates were performed because those providers had not complained about the adequacy of rates. We noted that there are possible indications of excessive rates for certain PRP services. Specifically:

- PRP rates do not provide for discounts when consumers are treated in group therapy, even though the Administration's rates for non-PRP services do provide for such discounts. For example, if eight patients were seen in group therapy for one hour by a psychiatrist, the psychiatrist would be paid $184. The same eight consumers receiving off-site PRP treatment which is normally provided by a non-medical professional employee would cost the Administration $424, which is eight times the $53 individual rate for a one-hour off-site treatment. Considering that the costs of provider employees rendering PRP services are relatively low, there is much opportunity for provider revenues to exceed costs for services provided as the PRP rates are presently structured. We noted that group discounts for mental health services is a practice in other states. For example, in one state the group rate per person is 60% less than the individual rate.

Group treatment discounts are not available for PRP services. For example, 8 consumers in a one-hour PRP treatment cost the State $424 versus $184 for a one-hour group therapy session with a psychiatrist.

- The rate structure for individual treatment services does not appear to provide an appropriate number of different rates for various periods of service. For example, the reimbursement rate for certain off-site treatments (such as in a consumer's group home) is $50 for a 15 to 60 minute period. We question whether the provider payment should be the same for a 15-minute service as for a 60-minute service. For example, a provider who, over the course of an hour, treated four consumers who reside in the same group home—each for the minimum of 15 minutes—would be reimbursed $200 ($50 x 4). That same provider would receive only $50 if the hour were spent with only one consumer. In fact, we noted numerous examples in which services were provided in exactly 15-minute intervals, including one day in which one provider's employee rendered 13 services of exactly 15 minutes each. We noted that certain Medicaid procedures were billed in 15-minute intervals.

When we discussed our concerns about the PRP rate structure with the Administration's management, they acknowledged that PRP services could be profitable for providers. We were advised that part of the program's dramatic growth could be attributed to providers realizing the profitable nature of PRP services and requesting (and receiving) authorization for extra services. During our review of the objective addressing the claims payment process, we also noted significant problems with the PRP that prevented the Administration from ensuring that only appropriate services were provided and that the Program was achieving its intended results (Findings 6 and 7).

Recommendation 1

We recommend that the Administration conduct a formal analysis of the adequacy of its PRP rates. This analysis should include a consideration of providers' labor costs and also address the feasibility of group discounts and establishing additional rate categories that more closely correlate with the actual time consumers receive services. Furthermore, this analysis should be performed in conjunction with the Department of Health and Mental Hygiene's efforts to comply with Chapter 464 of the Laws of Maryland for 2002, which requires the establishment of an annual process to reassess the rates for the public mental health system.

Finding 2
The Administration did not formally consider in the RRP fee structure the value of benefits received for RRP consumers by the providers.

Analysis
Even though Administration officials stated that the Residential Rehabilitation Program (RRP) rates were set lower in consideration of the benefits retained by providers on behalf of the consumers (such as social security benefits), the Administration had no information on the number of RRP consumers that even received such monthly benefits. Furthermore, the Administration could not document the reasonableness of the related RRP fee structure. During fiscal year 2002, the total provider payments for RRP are projected to be $26 million.

Our review of 30 randomly selected RRP consumers from several different providers disclosed that 23 received benefit checks were retained by providers. During fiscal year 2002 the average benefit amount for these 23 consumers was $572 per month, and there were approximately 2,100 RRP consumers in the program. Accordingly, this is a significant financial resource that should be considered when determining the rates.

Recommendation 2
We recommend that the RRP rates be periodically adjusted to account for the financial effect of the actual resources received by the providers and that this be properly documented. Furthermore, this analysis should be performed in conjunction with the Department of Health and Mental Hygiene's efforts to comply with Chapter 464 of the Laws of Maryland for 2002, which requires the establishment of an annual process to reassess the rates for the public mental health system.

Finding 3
Expansion of a capitation program could result in annual cost avoidance of approximately $9 million.

Analysis
Significant cost savings could be realized if a program that uses capitation rates (fixed fee per consumer) instead of the fee-for-service payment methodology was expanded to a larger portion of the Administration's consumer base. The terms of the existing capitation program provide for two providers to be paid a fixed amount ($76 per day or $27,500 annually) to generally render all mental health

services for each adult consumer in Baltimore City who elects to enroll in the program. During fiscal year 2002, the program served approximately 250 consumers each month. The Administration estimated that it could save $9 million each year if the program was expanded to serve 500 eligible high cost children and adolescents located throughout the State. Since the Administration has identified over 1,000 children and adolescents who may be eligible for this program, due to the voluntary nature of the program, the Administration's estimate of 500 appears reasonable. We found that significant savings had been realized by another State that had implemented a similar process.

Although we were advised that the Administration believes that expansion of the program is viable, eligibility was initially restricted to adult consumers because it thought that the Department's Medical Care Programs Administration would not allow additional capitation claims to be processed through its system to recover the Federal funds for Medicaid eligible consumers. However, when we discussed expansion of the program with officials of the Medical Care Programs Administration, we were advised that the additional claims applicable to Medicaid consumers could be submitted for Federal reimbursement.

Recommendation 3
We recommend that the Administration expand the capitation program to include additional consumers, as appropriate, to realize the maximum savings possible.

Specialty Hospital Rates

A specialty hospital that treats children and adolescents with certain specific disorders is projected to receive payments of $16 million during fiscal year 2002, making it the Administration's largest paid provider. Because this specialty hospital's rates are not established by the Health Services Cost Review Commission, payments are on a cost reimbursable basis as required by State regulations. Specifically, hospital payments are based on an interim rate, and at the end of each fiscal year, the hospital submits a cost report to the Medical Care Programs Administration (MCPA). This report compares the payments received from State agencies with the actual hospital charges, and is to be reviewed on an annual basis by an independent accounting firm under contract with the MCPA. As part of its review of the cost report, the firm calculates an amount the hospital owes the State or an amount the State owes the hospital.

Finding 4
Although cost reports have been submitted by the specialty hospital for fiscal years 1994 through 2001 the settlements have not been finalized, preventing the recovery of anticipated overpayments.

Analysis
Fiscal year 1993 was the last year for which the cost settlement process has been finalized for this specialty hospital. Although cost reports were submitted by the hospital for fiscal years 1994 through 2001, as of November 2002, the accounting firm has not completed its review of those reports, preventing the Administration from recovering any overpayments for subsequent years. We have been informed that the firm's delay in completing the settlements is partially attributable to outstanding issues between the State and the hospital regarding the disallowance of certain costs claimed by the hospital.

The finalized cost settlements for fiscal years 1992 and 1993 resulted in the hospital reimbursing the State approximately $1.9 million. According to the hospital's audited financial statements for fiscal year 2002, the hospital estimates it owes the State $4 million for the cost settlements that have not been finalized. An MCPA official advised us that the actual amount could be higher.

A potential $4 million is owed the State from incomplete hospital cost settlements for fiscal years 1994 to 2001.

The responsibility for monitoring the independent accounting firm's progress toward completing the cost settlements rests primarily with the Department's Medical Care Programs Administration. However, given that this is the Administration's largest paid provider, and considering the significance of the potential for recovery of funds and the related loss of interest income to the State, we believe the Administration should work with the Medical Care Programs Administration in this effort.

Recommendation 4
We recommend that the Administration, in conjunction with the Medical Care Programs Administration, ensure that outstanding cost settlements are finalized immediately and that future settlements are completed timely. We also recommend that any amounts owed as a result of the finalized cost settlements be collected from the hospital and the appropriate portions be deposited with the State's General Fund, or returned to the Federal government for shared costs.

Finding 5
There is no mechanism to ensure that rates charged by the specialty hospital are reasonable.

Analysis

There is no process in place to ensure that the specialty hospital's rates are reasonable. As previously mentioned, the Health Services Cost Review Commission (HSCRC) does not establish this specialty hospital's rates, but rather, payments are based on cost reimbursements. Even though an accounting firm reviews the hospital's costs in the cost settlement process, a supervisory employee from the accounting firm advised us that this review does not include assessing the reasonableness of the hospital's costs. Administration management advised us that they believed the hospital's rates appeared to be excessive. Since the hospital provides unique services to consumers who also have developmental disabilities (dually diagnosed children), higher rates are to be expected; however, the Administration could not provide specific justification (such as cost studies) for the differences. Furthermore, our comparison of this hospital's rates to the amounts paid to other providers suggests that the hospital rates are higher. Specifically:

- The hospital charges $345 per hour for individual outpatient therapy with medication management, while the rate paid by the Administration to outpatient mental health clinics for similar services provided to non-developmentally disabled children is $103 per hour. Similar differences were noted for services related to individual outpatient therapy without medication management. Fiscal year 2002 inpatient and outpatient costs for this hospital's services are projected to be $4 million and $12 million, respectively.

- The hospital's inpatient rate of $1,423 per day exceeded the rate charged by the majority of the intensive care units in Maryland's 45 acute care hospitals. This rate also greatly exceeded the daily charge for a psychiatric acute care room in those same hospitals, which generally ranged from $500 to $850.

As part of its process for setting rates for acute care hospitals, the Health Services Cost Review Commission (HSCRC) advised us that it does review hospital costs for reasonableness. Similarly, we believe the Administration should involve the HSCRC in establishing rates for this specialty hospital.

Finally, the costs for services provided to these children with developmental disabilities were paid fully by the Administration, and were not shared with the Developmental Disabilities Administration. Although this practice was acknowledged to occur, the Administration had not documented the financial effect of this practice.

Recommendation 5
We recommend that the Administration, with the assistance of the Department's Health Services Cost Review Commission, evaluate the current payment process for this hospital. Furthermore, this analysis should be performed in conjunction with the Department of Health and Mental Hygiene's efforts to comply with Chapter 464 of the Laws of Maryland for 2002, which requires the establishment of an annual process to reassess the rates for the public mental health system. We also recommend that the Department address the issue of funding for dually diagnosed children.

Adequacy of Claims Payment Process

Conclusion
Our audit identified opportunities for improvement in many areas of the Administration's claims payment process for mental health services. While certain deficiencies were found to exist in specific programs, many were widespread. The Administration, for example, could not be sure that only legitimate medically necessary mental health services were authorized by the ASO because these decisions were not independently reviewed or evaluated by the Administration, even though required by State regulations.

Significant funds were lost when the Administration instructed the ASO to pay claims submitted beyond the timeframe established by State regulations. An additional $3.1 million was lost when collection efforts against a current provider were halted and the debt abated without adequate justification. Since the provider is still active, the Administration should have collected the debt by offsetting it against future payments. Furthermore, the Administration's post-payment claims review process was not comprehensive. For example, claims related to hospital in-patient costs—projected to exceed $80 million in fiscal year 2002—were not included in these reviews and follow-up on claim reviews results were ineffective. Providers with potential disallowances of $220,000 resulting from the fiscal year 2000 claims reviews were not notified for two to three years. Finally, $4.5 million was lost when Federal reimbursement was not sought timely for paid claims and related expenses.

We also noted significant problems with the Psychiatric Rehabilitation Program (PRP) that prevented the Administration from ensuring that only appropriate services were provided and that the Program was achieving its intended results. Over $110 million is projected to be spent in PRP in fiscal year 2002. The treatment authorization and provider claims submission processes for the Program were not specific about the nature of services to be provided, making it difficult for the Administration to determine the appropriateness of treatment. For example, the ASO's claims review contractor noted that, over a seven-month period, ten consumers received PRP services that included almost 900 shopping or recreational trips, at a cost to the State of $60,000. The contractor, including independent medical personnel concluded that these services were too numerous and not necessary. When we reviewed actual detailed treatments from consumer case files there also appeared to be an excessive number of such services. Given the funding level of this program, there needs to be more accountability established and a periodic evaluation of the program's success.

The parent company of the ASO that provides the treatment authorization, claims processing (using its own proprietary software) and post-payment review is experiencing financial distress and the Administration has not developed a comprehensive contingency plan that includes continuation of the existing controls if the ASO were to cease operation. The Administration has also not satisfactorily resolved the status of the large State advance given to the ASO.

Finally, there were also inconsistent State regulations governing the required level of documentation to support provider claims for payment. The regulations established by the Administration were less stringent than those of the Medical Care Program Administration for Medicaid. This situation limits the Administration's ability to assess the reasonableness of services being paid. Also, this situation could result in another significant problem since we were advised that the courts could hold a provider to the lesser standard if legal action was ever taken by the State for questionable claims. Our limited review of provider files indicates that the less stringent standard appears to be followed by the providers.

Finding 6
The treatment authorization process and the regulations governing the PRP services did not ensure that only necessary services are rendered to consumers.

Analysis
The ASO's treatment authorizations for PRP services and related provider billings were not specific. Treatment authorizations do not describe services to be provided. Rather, they only authorize a total number of service units to be provided to the consumer. In addition, the related provider claims only specified treatment codes, such as a brief visit, a standard visit or an extended visit. Furthermore, provider-staffing guidelines were not formalized, to ensure that consumers received appropriate supervision. Coupling this lack of specificity with the generic nature of the program's regulations means that there is no restriction on the types of services that providers can furnish and still qualify for payment. Moreover, it means that neither the Administration nor the ASO had any comprehensive data on the nature of PRP services that were actually provided and had no effective mechanism to assess the necessity of the services provided. For example,

- An April 2002 claims review of 17 consumers at one PRP provider, performed by the ASO's claims review contractor, disclosed that PRP services provided to 10 of the consumers included a large number of shopping trips and miscellaneous recreation activities (such as trips to the park, bowling, playing pool). The review report stated that,

  "In reviewing the services, it is the opinion of the auditors [including medical professionals] *that the frequency of shopping, and visiting the park was too numerous and not necessary for the rehabilitation of the consumer."*

  During the approximate seven-month period reviewed by the contractor, the PRP services provided to these 10 consumers included over 450 shopping trips and over 440 recreational activities, at an approximate average cost of $67 each which represented a total cost to the State in excess of $60,000. During our visits to providers we also noted numerous instances of these types of services. The provision of these services would generally be consistent with the PRP

Over a 7-month period, 10 consumers went on almost 900 shopping or recreational trips at a cost to the State of $60,000.

treatment authorizations since those authorizations are not required to be specific as to the type of services to be provided.

- PRP regulations do not contain a limit on the size of a PRP group that can be supervised by one provider employee, but rather state that for each provider there must be "an average ratio of at least one rehabilitation staff member serving each eight individuals." From our review of provider files and visits to provider locations, we noted numerous instances of large group activities exceeding the specified average of one staff member for eight consumers. For example, we noted 17 consumers in off-site activities (such as shopping) supervised by a single employee, and on-site groups with up to 23 consumers that were supervised by a single employee. This raises the question of whether a single employee can safely supervise and effectively treat such large groups of consumers.

During fiscal year 2002, this program, at a projected cost of $110 million, served over 20,000 consumers.

Recommendation 6

We recommend that Administration require the identification of the specific PRP services (recreation, shopping, counseling, medication monitoring) authorized. We also recommend that these revisions include a requirement that providers report the specific nature of PRP services provided, and that the Administration analyze the reported data and take action against those providers providing services that are not prescribed by the treatment plan. Finally, formal maximum staffing ratios should be established for specific services to ensure the effectiveness of treatment and consumer safety.

Finding 7

The Administration did not formally evaluate the effectiveness of the Psychiatric Rehabilitation Program (PRP).

Analysis

The Administration did not monitor or evaluate the success of the PRP in delivering services that, in many instances, are designed to transition consumers to independent living which, according to an official of the ASO, is the intent of the Program. State Regulations also state that PRP services should facilitate the development of an individual's independent living and social skills and promote the use of community resources to integrate the individual into the community. If the rehabilitative services are successful, eventually the majority of the patients should

experience a reduction in services. Given the significant growth in this Program in the past five years (projected to be an 80% increase), such a determination of the Program's effectiveness would be appropriate. However, the Administration does not maintain any Program data to determine if consumers of PRP services are eventually able to live independently and if the amounts of services consumers receive diminish over time.

Recommendation 7

We recommend that the Administration maintain and formally analyze Program data to evaluate the success of the PRP and make modifications as deemed appropriate. Specifically, the Administration should consider the length of time patients undergo treatment and if expected results are obtained from those treatments.

Finding 8

The Administration did not review the medical necessity decisions made by the ASO for all mental health services.

Analysis

The Administration did not review or otherwise evaluate the decisions made by the ASO regarding the authorization of mental health services (type of services and number of treatments), as required by State regulations. Consequently, the Administration lacked assurance that only legitimate medically necessary services were authorized. Besides being required by State regulations, the review of such authorization decisions is critical to provide the Administration with a means of monitoring the performance of the ASO, which is responsible for authorizing over $400 million in mental health services on the Administration's behalf.

Recommendation 8

We recommend that the Administration develop a process to periodically evaluate the appropriateness of the medical necessity decisions made by the ASO. This process should include a review by medical professionals of a sample of patient medical records and the related treatment authorization decisions made by the ASO. A risk-based selection process should be used for the sample and, at a minimum, the reviewer should address the more expensive services and unusual trends.

Finding 9
The ASO's parent company has experienced recent financial difficulties, but the Administration had not developed a contingency plan to assume the processing of mental health claims if the ASO discontinues operations.

Analysis

Although the corporation that owns the ASO is experiencing severe financial difficulties, the Administration has not developed a contingency plan if the ASO ceases operations. The parent company reportedly has approximately $1 billion of debt that it may not be able to repay and it is attempting to restructure some of its outstanding debt. During the past year, the stock price of the ASO's parent company has declined over 90% in value and, as of November 22, 2002, was trading under $1 per share (14 cents). The ASO performs benefit management services for the public mental health system, such as authorizing mental health services, processing claims (utilizing the parent company's propriety software and data system), verifying that billed services included in claims were authorized and submission of claims for Federal reimbursement. The current ASO contract was effective January 1, 2002 for a period of 18 months, with three one-year renewal periods.

A further consideration is that, according to the Administration's records, outstanding funds advanced to the ASO totaled approximately $27 million as of June 30, 2002. However, we could not readily verify this amount because, as commented upon in our two preceding fiscal/compliance audit reports on the Administration, funds paid since fiscal year 1998 to the ASO for claims (including advances) have never been fully accounted for. Therefore, State monies could be at risk if the parent company were to seek bankruptcy protection.

Advances made by the Administration to the ASO that totaled $27 million as of June 30, 2002 were potentially at risk.

Recommendation 9

We recommend that the Administration develop a plan to continue the public mental health system if the ASO ceases operations and to ensure that State funds are safeguarded. The plan should address all of the critical functions currently performed by the ASO such as authorization of services, verifying that services billed were authorized, paying providers and submitting claims for Federal reimbursement.

Finding 10
The Administration had not established criteria to determine consumer eligibility for intensive level services in the Residential Rehabilitation Program (RRP).

Analysis
The Administration lacked criteria for consumer eligibility for intensive level services in its Residential Rehabilitation Program (RRP). Rather, eligibility decisions were made on an individual basis by the core service agencies, a process that could easily result in inconsistent classification of consumers. Consumers in the RRP either received general support, at a rate of $18 per day, or intensive support services at a rate of $44 per day. Consumers who receive the more expensive intensive services are to be supervised in their residence at least 40 hours per week by a provider employee. Without formal eligibility criteria, there is lack of assurance that the more expensive services are only provided to consumers who actually require them. Approximately 58% of RRP consumers receive the intensive services. Payments related to RRP intensive level staffing services provided during fiscal year 2002 are projected to total approximately $12.7 million.

Recommendation 10
We recommend that the Administration establish specific criteria to determine patient eligibility for RRP intensive level staffing services and ensure that only eligible consumers receive these services (for example by including these consumers in the medical necessity review recommended in Finding 8).

Finding 11
Regulations regarding documentation that providers must maintain to support their billed mental health services were inconsistent with State Medicaid regulations that covered many of the same services.

Analysis
State regulations regarding the documentation required for services provided and billed, were inconsistent with, and less stringent than State Medicaid regulations that covered many of the same mental health services. Specifically, State Medicaid regulations for mental health services require providers to document all services with the date of service, a description of the service provided, and a signature of the employee who provided care. However, regulations established by the

Administration for certain programs impose a much less stringent documentation requirement on providers. For example, the PRP regulations do not require providers to describe each service provided or require the employee providing the service to sign any documentation. According to Administration records about $200 million of its fiscal year 2002 expenditures are governed by these inconsistent regulations.

Less stringent regulations limit the Administration's ability to assess the reasonableness of services being paid for. Additionally, the Management of the Department's Medicaid Fraud Control Unit advised us that courts tend to hold providers to the lesser standard when multiple and inconsistent regulations are in effect.

Recommendation 11
We recommend that the Administration revise its regulations so that the procedures providers must follow to document the provision of services are consistent with State Medicaid regulations.

Finding 12
The Administration instructed the ASO to pay claims that were not submitted within the time limit established by State regulations.

Analysis
Numerous claims that were submitted more than nine months after services were provided were routinely paid by the ASO based on the Administration's direction, or in some cases, as the result of errors made by the ASO. State regulations require that for a claim to be paid, it must be submitted within nine months after service was rendered and, generally, Federal regulations provide for reimbursement of the claims within two years from the date of payment. We performed a computer analysis of the ASO's paid claims for services provided during fiscal year 2001. According to this analysis, $7.6 million in claims submitted more than nine months after the services were provided were paid by the ASO.

All $7.6 million may not have been inappropriately paid because there are legitimate reasons for paying certain claims that are submitted more than nine months after the services were provided. For example, claims that are submitted timely, rejected and resubmitted within two months of the expiration of the nine-month filing period can be paid. To account for this occurrence, we performed a test of 30 randomly selected claims included in the $7.6 million, and found that for

16 claims there was no documented legitimate rationale for payment. For some of the 16, the Administration instructed the ASO to pay claims for certain providers in clear violation of State regulations.

Recommendation 12
We recommend that the Administration ensure that only claims that are submitted on a timely basis in accordance with State regulations are paid.

Finding 13
The provider claims review process was not comprehensive and follow-up on the results of claims reviews was inadequate.

Analysis
The claims review process for Administration funded services was not comprehensive, since all claims were not subject to review and follow-up of potential disallowances was not timely. As required by its contract with the Administration, the ASO hires an independent company to review randomly selected claims by reviewing medical records to determine if services reimbursed by the Administration were actually provided. The findings are reported to the Administration for corrective action including the recovery of potential overpayments. However, we noted significant problems with the review process. Specifically:

- Hospital inpatient claims, which are projected to total over $80 million for fiscal year 2002 were excluded from the claims review process, and not otherwise reviewed.

- Provider reviews were conducted randomly, rather than through a risk-based selection process to identify potentially fraudulent claims or problem providers. A risk-based provider selection process should involve a computerized analysis of claims that considers such factors as the frequency of certain services, the frequency of expensive services, and high-dollar providers, as well as the results of prior claim reviews. For example, a May 2000 claims review of only 10 consumers at one randomly selected provider, disclosed over 1,000 undocumented claims totaling

The claim review process was inadequate. For example, one May 2000 review of 10 consumers at one provider disclosed over 1,000 cases of undocumented claims totaling $59,000, but the review was not expanded.

approximately $59,000. In spite of these results, additional claims were not selected for review during that year and the provider was not reviewed in the subsequent year. Of the approximately 1,300 providers in the public mental health system, because of limited resources only 17 were subject to a claims review during fiscal year 2002. However their selection was not risk-based. Accordingly, a risk-based approach, similar to one used by Medical Care Programs Administration for Medicaid claims, would be more effective and efficient.

- We also noted that the follow-up process on the results of claims reviews was inadequate. For example, the Administration took two to three years to notify 23 providers of the results of fiscal year 2000 claims reviews (including the aforementioned May 2000 claims review), which had potential disallowances of over $220,000. The collectability of these funds is unknown at this time since the recovery of disallowances cannot be made until the providers are given sufficient opportunity to respond to the reviews.

Recommendation 13

We recommend that the Administration develop a comprehensive claims review process. This process should include all services, including inpatient hospital services, and use a risk-based claims analysis system (that would also consider the results of prior reviews) to identify expensive, unusual or suspicious claims and providers for review. Furthermore, if a review of a provider discloses more than a specified percentage of undocumented claims, additional claims should be selected for review. Finally, providers should be notified of the results of their claim reviews within a reasonable period (such as, 60 days after completion of the review) and reimbursement requests for disallowed claims should be made timely.

Finding 14

The Administration could not justify the suspension of collection efforts against a provider that owed the State $3.1 million, nor could the Department support its subsequent recommendation to abate the debt.

Analysis

The Administration discontinued collection efforts against a current provider that owed the Administration $3.1 million in outstanding advances and transferred the account to the State's Central Collection Unit without pursuing all means of collection. According to Central Collection Unit management, the debt was

abated at the request of the Department of Health and Mental Hygiene. The Department's rationale for abatement was that the provider had rendered services for which they had not been paid. However, neither the Department nor the Administration could provide details that adequately documented these services. Furthermore, the ASO was unable to provide us with adequate detail of valid services rendered but not reimbursed. Therefore, there was a lack of evidence to indicate that the State had received services for the $3.1 million payment. Since the provider is still active and receiving payments for services provided to consumers, the Administration could have collected the debt by offsetting it against future payments in accordance with the Unit's regulations.

This debt originated when the ASO provided advances to providers during the implementation of the public mental health system, because the ASO encountered difficulty in processing claims in a timely manner. According to ASO records, since the inception of the fee-for-service payment system in 1998, the provider in question has been paid approximately $6.5 million for mental health services (excluding advances) provided to consumers. The Administration was also unable to explain why the provider received initially such a large advance (over $5 million), when its average annual payments were approximately $1.3 million.

Recommendation 14
We recommend that, in the future, the Administration strictly comply with State Central Collection Unit regulations when collecting outstanding balances from current providers by offsetting debt against future payments.

Finding 15
The Administration did not recover potential Federal fund cost reimbursement for claims totaling at least $4.5 million.

Analysis
Significant Federal funds were lost because the Administration did not take timely and appropriate action to seek all available funding. For example, we estimate that approximately $4.5 million in Federal funds were lost related to the capitation program since its inception in 1995 through March 2000 because Federal approval for participation was not sought promptly. Furthermore, once approval was obtained, capitation claims were not submitted timely for reimbursement in accordance with the Federal requirements. Federal regulations require claims for reimbursement to be submitted within two years after the quarter when the expenditures were made, and because certain of these claims are beyond the two-year limit they can no longer be submitted for reimbursement.

The Administration was unable to explain why Federal approval was not obtained promptly and claims submitted in a timely manner; however, in June of 2002 the Administration did receive Federal reimbursements related to the capitation program for fiscal years 2000 through 2002 totaling approximately $2.5 million. Our audit report on the Administration dated February 2002, and the Administration's response, previously addressed this Federal funds issue.

Recommendation 15

We recommend that, in the future, the Administration take appropriate action to promptly recover all available Federal funding.

APPENDIX

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Parris N. Glendening, Governor - Arlene F. Stephenson – Acting Secretary

December 23, 2002

Mr. Bruce Myers, CPA
Legislative Auditor
Office of Legislative Audits
301 West Preston Street
Baltimore, Maryland 21201

Dear Mr. Myers:

This is in response to your December 11, 2002 letter that included the draft audit report for the Mental Hygiene Administration's Community Services Program. Attached you will find the Department's plan of correction that addresses each audit recommendation. I will work with the appropriate Directors of Administration, Program Directors, and Deputy Secretary to promptly address all audit exceptions. In addition, our Division of Internal Audits will follow-up on the recommendations to ensure compliance.

If you have any questions or require additional information, please do not hesitate to contact me at (410) 767-6505 or Larry Triplett of my staff at (410) 767-5228.

Sincerely,

Arlene Stephenson

Arlene Stephenson
Acting Secretary

cc: Diane Matuszak, Acting Deputy Secretary, PHS
Dr. Brian Hepburn, Interim Executive Director, MHA, DHMH
Ms. Deborah I. Chang, Deputy Secretary for Health Care Financing, DHMH
Mr. Lawrence Triplett, Inspector General, DHMH

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Findings and Recommendations

Adequacy of Rate Setting Process

Finding 1
The Administration could not document how the rates for certain rehabilitation services were developed. Furthermore, the rates did not provide for group discounts and, in certain cases, did not take into account different periods of service.

Recommendation 1
We recommend that the Administration conduct a formal analysis of the adequacy of its PRP rates. This analysis should include a consideration of providers' labor costs and also address the feasibility of group discounts and establishing additional rate categories that more closely correlate with the actual time consumers receive services. Furthermore, this analysis should be performed in conjunction with the Department of Health and Mental Hygiene's efforts to comply with Chapter 464 of the Laws of Maryland for 2002, which requires the establishment of an annual process to reassess the rates for the public mental health system.

Response:
The Administration agrees with the recommendation that the Administration conduct a formal analysis of its PRP rates, and consider the feasibility of group discounts and additional categories. However, the Administration had utilized a methodology for establishing PRP rates, and factored in State General Funds for funding non-Medicaid individuals. The pre-1997 rate was actually higher for on-site PRP services. The Administration currently has retained a health care financial consultant to perform a review, and a final report is due in February 2003. The Administration will review these in conjunction with the Community Services Reimbursement Rate Commission, who has reviewed our rates since 1998.

MENTAL HYGIENE ADMINISTRATION
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RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Finding 2
The Administration did not formally consider in the RRP fee structure the value of benefits received for RRP consumers by the providers.

Recommendation 2
We recommend that the RRP rates be periodically adjusted to account for the financial effect of the actual resources received by the providers and that this be properly documented. Furthermore, this analysis should be performed in conjunction with the Department of Health and Mental Hygiene's efforts to comply with Chapter 464 of the Laws of Maryland for 2002, which requires the establishment of an annual process to reassess the rates for the public mental health system.

Response:
The Administration agrees with the recommendation, and in conjunction with its consultant, will perform the recommended analysis and review of its RRP rates, and the income received by the RRP to evaluate the total cost of the RRP service. The Administration did make projections on estimated fee collections from RRP consumers when it developed its rates for RRP. The same method was used for the contract system prior to 1997. As always, any decision to adjust the rates will reflect the effort to maximize Federal dollars. The annual review will be completed by February 4, 2003.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Finding 3
Expansion of a capitation program could result in annual cost avoidance of approximately $9 million.

Recommendation 3
We recommend that the Administration expand the capitation program to include additional consumers, as appropriate, to realize the maximum savings possible.

Response:
The Administration agrees with the recommendation for expansion of capitation. However, the Administration is not aware of the projected $9 million cost avoidance associated with expansion of a capitation program. In early September, MHA appointed a workgroup of stakeholders chaired by the office of Baltimore Mental Health Systems (Baltimore City CSA) to review the potential for expansion of the capitation project (or similar models) to other areas of the State. The decision to extend the capitation project will depend on the results of the workgroup, the willingness of consumers to participate and available financing. Expansion of the capitation project will be done in a cautious and systematic manner to ensure that the clinical needs of high-risk individuals are not jeopardized. In addition, children and adolescents move off the high cost user list rapidly and focusing on that group for capitation may increase costs rather than decrease costs. Review and recommendations should be complete by February 4, 2003.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Specialty Hospital Rates

Finding 4
Although cost reports have been submitted by the specialty hospital for fiscal years 1994 through 2001 the settlements have not been finalized, preventing the recovery of anticipated overpayments.

Recommendation 4
We recommend that the Administration, in conjunction with the Medical Care Programs Administration, ensure that outstanding cost settlements are finalized immediately and that future settlements are completed timely. We also recommend that any amounts owed as a result of the finalized cost settlements be collected from the hospital and the appropriate portions be deposited with the State's General Fund, or returned to the Federal government for shared costs.

Response:
The Administration agrees that cost settlements should be completed in a timely fashion. However, there are circumstances and complexities which have prevented the cost settlements from being finalized. The Medical Care Programs Administration is responsible for conducting the audits and cost settlements.

This particular provider has a history of complicated issues that need to be resolved first to avoid additional expense in the appeal of the cost settlement. Some of the complicated issues delaying fiscal years 1994 through 2001 cost settlements include: the offset of board-designated endowment fund income against interest expense, outpatient cost reductions factors, outpatient physician billings, allocation of research expense between clinical and bench research, allocation of physician cost between professional and provider component, review of exceptions to the cost limits, the merger of an out-of-state children's hospital with the specialty hospital, the refinancing of long-term debt and the related loss on early extinguishment of debt, the break-out of general service cost centers, proper matching of outpatient cost and charges, depreciation expense on newly acquired buildings and equipment, and related party transactions.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
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MCPA and the audit firm are currently considering plans to settle two cost report years each fiscal year. More than two cost reporting years cannot be settled in a State fiscal year because the current cost report is compared to the prior year final settled cost report to identify potential problem areas. Also, due to the complicated cost report issues mentioned above, additional review of documentation and communication between the specialty hospital and the audit firm is required. As such, it is impractical to settle more than two cost reports per fiscal year. Fiscal years 1994 through 1996 are in the process of being reviewed.

When the cost settlements are completed, any amounts owed to the State will be recovered. The federal share will be refunded to the federal government.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Finding 5
There is no mechanism to ensure that rates charged by the specialty hospital are reasonable.

Recommendation 5
We recommend that the Administration, with the assistance of the Department's Health Services Cost Review Commission, evaluate the current payment process for this hospital. Furthermore, this analysis should be performed in conjunction with the Department of Health and Mental Hygiene's efforts to comply with Chapter 464 of the Laws of Maryland for 2002, which requires the establishment of an annual process to reassess the rates for the public mental health system. We also recommend that the Department address the issue of funding for dually diagnosed children.

Response:
The Administration disagrees with the findings and the related recommendations for this item. The reimbursement methodology for this specialty hospital is the responsibility of the Medical Care Programs Administration and is contained in applicable MCPA regulations. The specialty hospital must bill its customary charge; regulations require that this type hospital be reimbursed at the lesser of its customary charge or actual costs determined in accordance with Medicare reimbursement principles. This methodology is known as retrospective cost reimbursement.

The reimbursement methodology for this hospital does ensure that only reasonable costs incurred are reimbursed by the State of Maryland Medicaid Program. The mechanism in place is reflected in the Code of Maryland Regulations (COMAR), the Medicaid State Plan, Federal Regulations (42 CFR), and CMS Publication 15-1 (Provider Reimbursement Manual).

COMAR 10.09.06.09A (3) indicates that a general or special hospital not approved by the Program for reimbursement according to HSCRC rates shall be reimbursed according to Medicare standards and principles for retrospective cost reimbursement described in 42 CFR 413, or on the basis of charges if less than allowable cost. COMAR 10.09.06.09B (1) reflects that final settlement for services in the provider's fiscal year shall be determined based upon Medicare retrospective cost principles found at 42 CFR 413, adjusted for Medicaid

allowable costs. Allowable costs specific to the Maryland Medicaid Program shall be limited to a base year cost per discharge increased by the applicable federal rate of increase times the number of Maryland Medicaid discharges for that fiscal year.

With regard to reasonable costs, Section 1861(v)(1)(A) of the Social Security Act states "The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used…Such regulations may…provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services…" Thus, the cost reimbursement regulations in their entirety are the framework for determining reasonable cost. Reasonable cost is not simply a subjective determination applied to selected categories of cost.

The State of Maryland Medicaid Program receives cost reports from specialty hospitals, and subjects them to a detailed analysis designed to identify nonallowable and unreasonable costs before final settlement of the cost report is processed. The cost report verification process is similar to the process used by Medicare Fiscal Intermediaries in their review of Medicare Cost Reports.

The Maryland Medicaid cost report verification process includes the following:

1. Cost Report Acceptability Determination

The State audit firm has developed a Cost Report Acceptance Program/Checklist for each provider group to ensure that all information has been submitted. Improperly filed cost reports are not accepted and the Department is notified so that they may initiate a reduction in the Medicaid payments to that provider, if so warranted, until such time as the submission has been properly completed. The State audit firm has developed procedures within each desk review program to ensure that data is consistent between the various schedules.

2. Preliminary Desk Review designed specifically for hospitals

The State audit firm has developed procedures within each desk review program to ensure that non-allowable costs are excluded. The determination of the type of verification to be performed is based on various criteria. Placing a level of reliance on each item assesses these criteria. The desk review is performed to provide an initial assessment as to the proposed scope of the verification. Problems encountered during the desk review are flagged for later

investigation and could result in a field verification being scheduled. After the audit firm recommendation as to scope is made, the Program reviews and may approve or change the scope.

As a result of our audit firm's extensive knowledge of providers in Maryland, we have historically determined that the majority of the verifications should be limited scope verifications. The Program's limited audit resources should not be expended on a full scope verification unless there is an expected economic payback, either in real dollars or psychological deterrent impact. On a limited scope verification, the audit firm is able to tailor their procedures to identified problem areas and concentrate on those steps for which they anticipate an economic payback for the State. The flexibility of limited scope verifications allows them to increase their level of analysis at any time.

3. Engagement Planning Guide that considers materiality and specific areas/issues to be reviewed

The State audit firm supervisory personnel, based on their specific knowledge of that provider, make a determination of the scope of that verification. This scope determination is then reviewed by a Partner assigned to that provider group. This scope determination is documented in the Engagement Planning Guide. This Engagement Planning Guide, Scoping Sheet and various other relevant data are provided to the Department representative that visits the audit firm's office each week. This Department representative reviews the information and accepts or rejects the recommended level. The Department, within the Engagement Planning Guide, approves the ultimate level agreed upon between the parties.

4. Desk Review and/or Field verification as warranted by the areas/issues identified in the Engagement Planning Guide

A desk review verification is conducted in those situations where it has been determined that the provider's cost report includes only a few areas that require review or when a provider's costs are significantly over cost ceilings and any adjustments would have no impact on their final reimbursement. The level of work performed on a desk review can be expanded at any time.

There are some situations when problems encountered during the initial phase of a desk review would require that the scope be expanded to an on-site verification.

5. Adjustments proposed and Exit Conference held with Provider and Final Settlement issued

Upon the conclusion of each verification, the State audit firm issues a final settlement to the provider that includes adjustments made to the submitted cost report, a calculation of final settlement and if applicable, a management letter. In addition, the State receives a copy of the final settlement as well as an

accountant's report for the level of scope agreed upon. The final settlement is subject to an appeal process.

The process above requires an understanding of the Medicare principles of reimbursement as indicated in the CMS Publication 15-1. The CMS Publication 15-1 is a large volume of information that reflects CMS's interpretation of the Medicare laws and regulations. The Maryland Medicaid Program cost report verification process incorporates the manual provisions from the beginning to the end of the final settlement.

The rate comparisons included in the report are not appropriate ones because they compare services provided in a hospital setting to ones provided in a non-hospital setting. They compare a room and board rate, which does not include any ancillary services to an all inclusive rate which does include ancillary services, and they do not in any way compare similar levels of services of similarly complex disabled children with similar medical diagnosis. Many patients at this pediatric specialty hospital have been dually diagnosed with multiple medical, chronic psychological problems and are often referred from their community mental health providers. The specialty hospital's impatient unit is a severe behavior unit. The patients are typically diagnosed, many with severe to profound mental retardation and autism. These children often require high staff to patient staffing ratios with an emphasis on behavioral psychologists and other clinical providers due to the complex medical conditions of the children.

The administration also disagrees with the recommendation concerning the issue of funding for dually diagnosed children. The patients served at this pediatric specialty hospital are covered by medical assistance for their health care needs. The administration sees no efficiency to considering establishing multiple billing mechanisms.

The department is open to consideration of alternate reimbursement methodologies to simplify the complexities associated with this specialty hospital. The department will consult with the Health Services Cost Review Commission for their input in this matter.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Adequacy of Claims Payment Process

Finding 6
The treatment authorization process and the regulations governing the PRP services did not ensure that only necessary services are rendered to consumers.

Recommendation 6
We recommend that Administration require the identification of the specific PRP services (recreation, shopping, counseling, medication monitoring) authorized. We also recommend that these revisions include a requirement that providers report the specific nature of PRP services provided, and that the Administration analyze the reported data and take action against those providers providing services that are not prescribed by the treatment plan. Finally, formal maximum staffing ratios should be established for specific services to ensure the effectiveness of treatment and consumer safety.

Response:
The Administration disagrees with the recommendation that authorization be specific to the rehabilitation service. However, the Administration does agree with the recommendation to enhance compliance activities to review rehabilitation services to determine those of little therapeutic value and take action appropriately. The expectation is that PRP services are provided to individuals based upon the individual's rehabilitation goals and the individual's rehabilitation plan. PRP services are goal directed rehabilitation activities that support the development of community living skills and the individual's participation in community life. To accomplish this, PRP services may be provided at a facility, in the community, in the Residential Rehabilitation Program (RRP) residence, or an individual's home.

For a facility-based PRP a range of services and activities may occur during the day. This includes group and individual rehabilitation modalities and services that are directed at supporting the individual in the community. While the PRP regulations are programmatic and broader in content and expectation than the MA regulations, the Administration will add the policy from the MHP manual into the MA regulation. The Administration currently is in the process of revising the PRP and RRP regulations. Additional requirements to focus on goal directed activities

will be incorporated. The Administration will add detail to PRP regulations for specific requirements for facility-based PRP services to reduce the amount of services considered to be of little therapeutic value.

While all programs are expected to operate safely within their risk management policies, safety and supervision are generally not identified as specific needs or goals for most individuals with serious mental illness (i.e., there is nothing inherent in having a mental illness, especially if the individual is not in crisis, that would require safety and supervision to be a goal or need on an individualized rehabilitation plan).

The rationale for requiring an average 1:8 staff to client ratio is to be able to provide effective rehabilitation services. The exact ratio at any given time or with any given service depends on the goals and needs of the clients being served at the time and type of rehabilitation service being offered. Programs provide a wide range of services including individual rehabilitation planning, group activities, case coordination, and other activities. The ratio was intended to provide a minimum of 1 staff involved in direct service for every eight clients. This ratio may vary during the course of the day. In addition, since the daily census and consumer needs vary, programs need flexibility to deploy its staff in the most effective manner. The Administration believes the current requirement is adequate.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Finding 7
The Administration did not formally evaluate the effectiveness of the Psychiatric Rehabilitation Program (PRP).

Recommendation 7
We recommend that the Administration maintain and formally analyze Program data to evaluate the success of the PRP and make modifications as deemed appropriate. Specifically, the Administration should consider the length of time patients undergo treatment and if expected results are obtained from those treatments.

Response:
The Administration agrees with the recommendation that services to individuals should be monitored and will revise the PRP chapter to emphasize the need to transition individuals from this service when they have reached maximum benefit. However, before the Administration makes substantive changes to PRPs, the Administration will begin reviewing and analyzing PRP data by length of stay, severity of illness, by PRP program, etc. This review will identify various service delivery patterns, which may further identify problem areas.

The Administration will limit adult PRP service to individuals with serious mental illness and require referral by a mental health professional. This will provide greater assurance that the PRP service is directed to the most in need and is clinically appropriate.

It is anticipated that this can be accomplished by December 3, 2003.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Finding 8
The Administration did not review the medical necessity decisions made by the ASO for all mental health services.

Recommendation 8
We recommend that the Administration develop a process to periodically evaluate the appropriateness of the medical necessity decisions made by the ASO. This process should include a review by medical professionals of a sample of patient medical records and the related treatment authorization decisions made by the ASO. A risk-based selection process should be used for the sample and, at a minimum, the reviewer should address the more expensive services and unusual trends.

Response:
The Administration agrees with the recommendations. The MHA Office of Compliance, in conjunction with the MHA Clinical Director's Office, will develop a process to periodically evaluate the appropriateness of the medical necessity decisions made by the ASO, including a process for mental health professionals to evaluate whether treatment authorizations were appropriate. It is anticipated that this will be accomplished by December 3, 2003.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Finding 9
The ASO's parent company has experienced recent financial difficulties, but the Administration had not developed a contingency plan to assume the processing of mental health claims if the ASO discontinues operations.

Recommendation 9
We recommend that the Administration develop a plan to continue the public mental health system if the ASO ceases operations and to ensure that State funds are safeguarded. The plan should address all of the critical functions currently performed by the ASO such as authorization of services, verifying that services billed were authorized, paying providers and submitting claims for Federal reimbursement.

Response:
The Administration agrees with the recommendation; however, the Executive Committee of the Mental Hygiene Administration has already developed a plan with options in response to meet this contingency. Additionally, a meeting was held with the Deputy State Treasurer and the head of the State General Accounting Division to seek their advice. The Administration has followed their recommendations.

Additionally, the Administration has begun the process of transferring Public Mental Health claims payments to the Comptroller's Office. The target date for the Comptroller's Office to take over this responsibility is January 2003.

All funds are currently in an account in the name of only the State of Maryland; thus, no funds are at risk should Maryland Health Partners' (MHP) accounts be frozen in a bankruptcy proceeding. In addition all funds previously advanced to the ASO were used to pay provider claims.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Finding 10
The Administration had not established criteria to determine consumer eligibility for intensive level services in the Residential Rehabilitation Program (RRP).

Recommendation 10
We recommend that the Administration establish specific criteria to determine patient eligibility for RRP intensive level staffing services and ensure that only eligible consumers receive these services (for example by including these consumers in the medical necessity review recommended in Finding 8).

Response:
The Administration disagrees with the recommendation establishing specific and universal criteria to determine eligibility for RRP services. The Administration has had several workgroups to develop criteria specific to the intensive level of care. Based on the workgroups' efforts, it was decided that the local CSA is the most appropriate entity to review the individual's application to determine if the information provided supports the need and intensity of RRP service. This system has been clinically effective since it targets individuals in state hospitals, general hospitals, and individuals in the community that need an intensive level of care. Because the CSAs are at the county level, they have a greater familiarity with the individuals referred, their varying and complex needs, and the services and supports available in the community.

The Administration is in process of revising the RRP chapter to clarify the staffing requirements for intensive level of care. After the regulations are amended, the RRP referral guidelines will be revised to reflect those staffing requirements. This will be completed by December 2003.

The Administration will incorporate into written policy similar to the following:

Individuals must have a diagnosis of Serious Mental Illness and meet priority population criteria (includes impaired role functioning).
Exceptions to these diagnostic criteria will be made only for individuals currently in State psychiatric hospitals that require RRP services to be discharged and remain in the community. Additional criteria may include but is not limited to

one or more of the following: Criminal record, treatment and medication noncompliance, substance abuse use, aggressive behavior, lack of stable housing, psychiatric hospitalizations, extreme psychosis, poor reality testing,

The Administration has restricted upgrading the RRP level of care from general to intensive. To change the level of care requires the CSA and the MHA Director of Adult Services' approval. This is stated in the MHP provider manual. When MHA does give approval, the intensive bed is restricted to individuals discharged from state hospitals.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Finding 11
Regulations regarding documentation that providers must maintain to support their billed mental health services were inconsistent with State Medicaid regulations that covered many of the same services.

Recommendation 11
We recommend that the Administration revise its regulations so that the procedures providers must follow to document the provision of services are consistent with State Medicaid regulations.

Response:
The Administration agrees with the recommendation. However, providers in the PMHS contract to agree to follow Medicaid regulations. The Administration will continue to provide training to providers on corporate compliance. In addition, the Administration will also establish a process for the development and review of regulations. A number of chapters currently under revision have been amended to include documentation requirements that are consistent with the State Medicaid regulations. The Administration will continue to review and ensure that all regulations governing community services' documentation requirements are consistent, comprehensive, and complete. This will be completed by December 2003.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Finding 12
The Administration instructed the ASO to pay claims that were not submitted within the time limit established by State regulations.

Recommendation 12
We recommend that the Administration ensure that only claims that are submitted on a timely basis in accordance with State regulations are paid.

Response:
The Administration agrees with the recommendation that it ensure that only claims that are submitted on a timely basis be paid, and will maintain a record of all requests for suspension of edits, the decision regarding the suspension, and the justification for the decision. This is currently complete.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Finding 13
The provider claims review process was not comprehensive and follow-up on the results of claims reviews was inadequate.

Recommendation 13
We recommend that the Administration develop a comprehensive claims review process. This process should include all services, including inpatient hospital services, and use a risk-based claims analysis system (that would also consider the results of prior reviews) to identify expensive, unusual or suspicious claims and providers for review. Furthermore, if a review of a provider discloses more than a specified percentage of undocumented claims, additional claims should be selected for review. Finally, providers should be notified of the results of their claim reviews within a reasonable period (such as, 60 days after completion of the review) and reimbursement requests for disallowed claims should be made timely.

Response:
The Administration agrees with the recommendation that the ASO should develop a formal process to perform analyses of claims to identify providers for further review. The Administration will incorporate the recommended protocols. (The ASO currently reviews billing patterns, authorization usage, and expenditure information for this purpose. Reports on vendors with exceptionally high claims rejection rates are provided to the Administration.) Providers identified for follow-up will be forwarded to the ASO's independent contractor for compliance reviews and the Mental Hygiene Administration's Office of Compliance will monitor those reviews. Providers will be notified of the results of the claim reviews in a timely fashion.

The Administration agrees with the recommendation that claim reviews be performed for inpatient services. The Administration will require the ASO through its current contract to begin said reviews, and the Administration will specifically require the reviews in future ASO contracts.

These processes have begun and will be ongoing.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Finding 14
The Administration could not justify the suspension of collection efforts against a provider that owed the State $3.1 million, nor could the Department support its subsequent recommendation to abate the debt.

Recommendation 14
We recommend that, in the future, the Administration strictly comply with State Central Collection Unit regulations when collecting outstanding balances from current providers by offsetting debt against future payments.

Response:
The Administration continues to agree with the recommendation to comply with the regulations of the Central Collection Unit. In fact, the Administration followed those regulations when filing the claims in question to the CCU. The account in question was forwarded to the CCU because the Administration was unable to collect the advance. The Department was informed that CCU reviewed the provider's ability to pay and abated the debt, which, according to the Office of the Attorney General, precludes further collection activity.

MENTAL HYGIENE ADMINISTRATION
PERFORMANCE AUDIT
RESPONSE TO LEGISLATIVE AUDITOR'S RECOMMENDATIONS

Finding 15
The Administration did not recover potential Federal fund cost reimbursement for claims totaling at least $4.5 million.

Recommendation 15
We recommend that, in the future, the Administration take appropriate action to promptly recover all available Federal funding.

Response:
The Administration agrees that all possible federal funding should be recovered promptly. With regard to the long term care spans, MHA has received approval to forward invoices for the first month of service to MMIS II for processing. The week of November 9, 2002, MHP submitted those claims and $348,331 of the $1.2M processed. The remaining invoices had new error codes indicating a secondary problem in claim processing. MHP is working with staff of Medicaid Operations to resolve these problems.

Approval to bill for services under the Baltimore City capitation project was obtained in December 2001, which permitted MHA to recover federal claims from October 1999 forward. Approximately, six months claims were lost while programming changes were made to MMIS II. As the auditor has noted, recoveries have been made from March 2000 forward.

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